DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 7

2. STATE: Maine

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 8,200,000
b. FFY 02 $ 6,200,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See attached

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Principles of Reimbursement for Nursing Facilities
Maine Medical Assistance Manual, Chapter 3 Section 67

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Have not completed review

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kevin W. Concannon

13. TYPED NAME: Kevin W. Concannon

14. TITLE: Commissioner, Department of Human Services

15. DATE SUBMITTED: September 28, 2000

16. RETURN TO:
Christine Zukas-Lessard, Acting Director
Bureau of Medical Services
11 State House Station
VA Togus, Building 205
Augusta, Maine 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2000

18. DATE APPROVED: December 27, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Ronald P. Preston

21. TYPED NAME: Ronald P. Preston

22. TITLE: Associate Regional Administrator, DMSO

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

STATE OF MAINE

DEPARTMENT OF HUMAN SERVICES

PRINCIPLES OF REIMBURSEMENT

FOR

NURSING FACILITIES

EFFECTIVE JULY 1, 2000

Maine Medical Assistance Manual, Chapter III, Section 67

OFFICIAL

Tn. No.: 00-007
Supercedes
Tn. No.: 99-006

Approval Date: December 27, 2000 Effective Date: July 1, 2000

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INTRODUCTION

GENERAL PROVISIONS

10 PURPOSE

The purpose of these principles is to comply with Section 1902 (a) (13) (A) of the Social Security Act and the Rules and Regulations published thereunder (42 CFR Part 447), namely: to provide for payment of nursing care facility services (provided under Maine's Medicaid Program in accordance with Title XIX of the Social Security Act) through the use of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. These principles incorporate the requirements concerning nursing home reform provisions set forth by the Omnibus Budget and Reconciliation Act of 1987 (OBRA '87). Accordingly, these rates take into account the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well being of each Medicaid resident.

11 AUTHORITY

The Authority of the Department of Human Services to accept and administer any funds which may be available from private, local, State or Federal sources for the provision of the services set forth in the Principles of Reimbursement is established in Title 22 of the Maine revised Statutes Annotated, Section 10 and 12. The regulations themselves are issued pursuant to authority granted to the Department of Human Services by Title 22 of the Maine Revised Statutes Annotated Section 42(1).

12 GENERAL DESCRIPTION OF THE RATE SETTING SYSTEM

A prospective case mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. The rate is established in a two step process. In the first step, a facility's base year cost report is reviewed to extract those costs which are allowable costs. A facility's costs may fall into an allowable cost category, but be determined unallowable because they exceed certain limitations. Once allowable costs have been determined and separated into ~~four~~ three components - direct~~, indirect~~, routine and fixed costs, the second step is accomplished in which the costs which must be incurred by an efficiently and economically operated facility are identified.

13 EFFECTIVE DATE

These principles apply to reimbursement for all nursing facility services occurring on or after July 1, 2000.

14 REQUIREMENTS FOR PARTICIPATION IN MEDICAID PROGRAM

14.1 Nursing facilities must satisfy all of the following prerequisites in order to be reimbursed for care provided to Medicaid recipients:

14.11 be licensed and certified by the Maine Department of Human Services, pursuant to Title 22, Section 1811 and 42 CFR, Part 442, Subpart C, and

14.12 have a provider Agreement with the Department of Human Services, as required by 42 CFR, Part 442, Subpart B.

14.2 Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 14.1.

15 RESPONSIBILITIES OF OWNERS OR OPERATORS

The owners or operators of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner or a duly authorized representative shall in any way relieve the owner or operator of a nursing facility from full responsibility for compliance with the requirements and standards of the Department of Human Services or Federal requirements and standards.

16 DUTIES OF THE OWNER OR OPERATOR

In order to qualify for Medicaid reimbursement the owner or operator of a nursing facility, or a duly authorized representative shall:

16.1 Comply with the provisions of sections 15 and 16 and this section setting forth the requirements for participation in the Medicaid Program.

16.2 Submit master file documents and cost reports in accordance with the provisions of sections 30 and 32 of these Principles.

16.3 Maintain adequate financial and statistical records and make them available when requested for inspection by an authorized representative of the Department of Human Services, the state, or the Federal government.

16.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.

16.5 Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

16.6 Submit, such data, statistics, schedules or other information which the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the Department imposing the deficiency per diem rate described in Section 152 of these Principles.

20 ACCOUNTING REQUIREMENTS

20.1 ACCOUNTING PRINCIPLES

20.11 All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules require specific variations in such principles and Medicare Provider Reimbursement Regulations HIM-15.

20.12 The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operation efficiency.

20.13 The provider shall report on an accrual basis, unless it is a state or municipal institution that operates on a cash basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. The provider shall retain all such documentation for audit purposes.

21 PROCUREMENT STANDARDS

21.1 Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing Capital Assets. Such standards shall provide, and providers shall implement to the maximum extent practical, open and free competition among vendors. Providers are encouraged to participate in group purchasing plans when feasible.

21.2 If a provider pays more than a competitive bid for a Capital Asset an amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure it is an unallowable cost. In situations not competitively bid, providers must act as a prudent buyer as referenced in Subsection 24.2 in these principles. See cost to related organizations Section 24.9.

22 COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

22.1 Providers that have costs allocated from related entities included in their cost reports shall include as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements which must also be submitted with the Medicaid cost report. In the case of a home office, related management company, or real estate management company, this would include a completed Home Office Cost Statement which show the costs that are removed which are unallowable. The provider shall submit this reconciliation with the Medicaid cost report. If the nursing facility is a Medicare provider, the Medicare Home Office Cost report may be used to identify the unallowable costs that are removed, if the Medicare Home Office Cost report is completed in sufficient detail to allow the Department to make its findings.

22.2 No change in accounting methods or basis of cost allocation may be made without prior written approval of the Bureau of Medical Services.

22.3 Any application for a change in accounting method or basis of cost allocation, which has an effect on the amount of allowable costs or computation of the per diem rate of payment, shall be made within the first 90 days of the reporting year. The application shall specify:

22.31 the nature of the change;
22.32 the reason for the change;
22.33 the effect of the change on the per diem rate of payment; and
22.34 the likely effect of the change on future rates of payment.

22.4 The Department of Human Services shall review each application and within 60 days of the receipt of the application approve, deny or propose modification of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved.

22.5 Each provider shall notify the Department of Human Services of changes in statistical allocations or record keeping required by the Medicare Intermediary.

22.6 The capital component (any element of fixed cost that is included in the price charged by a supplier of goods or services) of purchased goods or services, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for the particular good or service and not classified as Property and Related costs (fixed costs) of the nursing facility.

22.7 Costs allocated to the nursing facility shall be reasonable and necessary, as determined by the Maine Department of Human Services pursuant to these rules.

22.8 It is the duty of the provider to notify the Division of Audit within 5 days of any change in its customary charges to the general public. A rate schedule may be submitted to the Department by the nursing facility to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the nursing facility.

22.9 All year end accruals must be paid by the facility within six (6) months after the end of the fiscal year in which the amounts are accrued. If the accruals are not paid within such time, these amounts will be deducted from allowable costs incurred in the first field or desk audit conducted following that six month period.

22.10 The unit of output for cost finding shall be the costs of routine services per resident day. The same cost finding method shall be used for all long-term care facilities. Total allowable costs shall be divided by the actual days of care to determine the cost per bed day. Total allowable costs shall be allocated based on the occupancy data reported and the following statistical bases:

22.10.1 Nursing Salaries. Services provided and hours of nursing care by licensed personnel and other nursing staff.
22.10.2 Other Nursing Costs. Nursing salaries cost allocations.
22.10.3 Plant operation and maintenance. Square feet serviced.
22.10.4 Housekeeping. Square feet serviced.
22.10.5 Laundry. Resident days, or pounds of laundry whichever is most appropriate.

22.10.6 Dietary. Number of meals served.
22.10.7 General and Administrative and Financial and Other Expenses. Total accumulated costs not including General and Administrative and Financial Expense.

23 ALLOWABILITY OF COST

23.1 If these principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used reference will be made first, to the Medicare Provider Reimbursement Manual (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

24 COST RELATED TO RESIDENT CARE

24.1 Principle. Federal law requires that payment for long term care facility services provided under Medicaid shall be provided through the use of rates which are reasonable and adequate to meet costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Costs incurred by efficiently and economically operated facilities include costs which are reasonable, necessary and related to resident care, subject to principles relating to specific items of revenue and cost.

24.2 Costs must be ordinary and necessary and related to resident care. They must be of the nature and magnitude that prudent and cost conscious management would pay for a specific item or service.

24.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Section 26.

24.4 Costs that relate to inefficient, unnecessary or luxurious care or unnecessary or luxurious facilities or to activities not common and accepted in the nursing home field are not allowable.

24.5 Compensation to be allowable must be reasonable and for services that are necessary and related resident care and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The compensation must be reported to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

24.6 Costs which must be incurred to comply with changes in federal or state laws and regulations and not specified in these regulations for increased care and improved facilities which become effective subsequent to December 31,1998 are to be considered reasonable and necessary costs. These costs will be reimbursed as a fixed cost until the Department calculates the Statewide peer group mean cost of compliance from the facility's fiscal year data following the fiscal year the cost was originally incurred. Following the second fiscal year the facility will be reimbursed the statewide average cost of compliance. The statewide average cost for this regulation/law will be built into the appropriate cost component in subsequent years.

24.7 Costs incurred for resident services that are rendered in common to Medicaid residents as well as to non-Medicaid residents, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

24.8 Lower of Cost or Charges. In no case may payment exceed the facility's customary charges to the general public for the lowest semi-private room rate in the nursing facility. These charges must be billed to private pay residents during the operating period they are incurred.

24.9 Cost to Related Organizations Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Providers should reference Section 21 of these Principles.

25 UPPER PAYMENT LIMITS

25.1 Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payments in 42 CFR. §447.272, using Medicare principles of reimbursement.

25.2 If the Division of Audit projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in subsection 25.4.

25.3 In computing the projections that Medicaid payments in the aggregate are within the Medicare Upper Limit, any facility exceeding 112% of the State mean allowable routine service costs, may be notified that additional information is required to determine allowable costs under the Medicare Principles of Reimbursement including any exceptions as stated in 42 CFR 413.30(f). This information may be requested within 30 days of the effective date of these regulations, and thereafter, at the time the interim rates are set.

25.4 Facility Rate Limitations if Aggregate Limit is Exceeded. If the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected Medicaid payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.

26 SUBSTANCE OVER FORM

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

27 RECORD KEEPING AND RETENTION OF RECORDS

27.1 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report, and must, upon request, make these records available to the Department, or the U.S. Department of Health and Human Services, and the authorized representatives of either agency.

27.2 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

27.3 The provider shall maintain all such records for at least three years from the date of filing, or the date upon the which the fiscal and statistical records were to be filed, whichever is the later. The Division of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

27.4 When the Department of Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty days the Department intends to reduce payments, unless otherwise specified, to a 90% level of reimbursement as set forth is Section 152 of these Principles. The notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

30 FINANCIAL REPORTING

31 MASTER FILE

The following documents concerning the provider or, where relevant, any entity related to the Provider, will be submitted to the Department at the time that the cost report is filed. Such documents will be updated to reflect any changes on a yearly basis with the filing of a cost report. Such documents shall be used to establish a Master file for each facility in the Maine Medicaid program:

31.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;
31.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Section 21;

31.3 Plant layout;

31.4 Terms of capital stock and bond issues;

31.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements;

31.6 Schedules for amortization of long-term debt and depreciation of plant assets;

31.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;

31.8 Related party information on affiliations, and contractual arrangements;

31.9 Tax returns of the nursing facility; and

31.10 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.

If any of the items listed in Subsections 31.1 - 31.10 are not submitted in a timely fashion the Department may impose the deficiency per diem rate described in Section 152 of these Principles.

32 UNIFORM COST REPORTS

32.1 All long-term care facilities are required to submit cost reports as prescribed herein to the State of Maine Department of Human Services, Division of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a nursing facility determines from the as filed cost report that the nursing facility owes moneys to the Department of Human Services, a check equal to 50% of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to offset the current payments to the facility until the entire amount is collected from the provider.

32.2 Forms. Annual report forms shall be provided or approved for use by long-term care facilities in the State of Maine by the Department of Human Services.

32.3 Each long-term care facility in Maine must submit an annual cost report within five months of the end of each fiscal year on forms prescribed by the Division of Audit. If available, the long-term care facility can submit a copy of the cost report on a computer disk. The inclusive dates of the reporting year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Division of Audit. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 152.

32.4 Certification by operator. The cost report is to be certified by the owner and administrator of the facility. If the return is prepared by someone other than the facility, the preparer must also sign the report.

32.5 The original and one copy of the cost report must be submitted to the Division of Audit. All documents must bear original signatures.

32.6 The following supporting documentation is required to be submitted with the cost report:

32.61 Financial statements,
32.62 Most recently filed Medicare Cost Report (if a participant in the Medicare Program),
32.63 Reconciliation of the financial statements to the cost report.
32.64 Any other financial information requested by the Department.

32.7 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

33 ADEQUACY AND TIMELINESS OF FILING

33.1 The cost report and financial statements for each facility shall be filed not later than five months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, the Department may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward but, reimbursement for the suspension period shall be made at the deficiency rate of 90%.

33.2 The Division of Audit may reject any filing which does not comply with these regulations. In such case, the report shall be deemed not filed, until refiled and in compliance.

33.3 Extensions to the filing deadline will only be granted under the regulations stated in the Medicare Provider Reimbursement Manual (HIM-15).

34 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT

34.1 Uniform Desk Review

34.11 The Division of Audit shall perform a uniform desk review on each cost report submitted.

34.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review. The Division of audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.

34.13 Uniform desk reviews shall be completed within 180 days after receipt of an acceptable cost report filing, including financial statements and other information requested from the provider except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.

34.14 Unless the Division of Audit intends to schedule an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

34.2 On-site Audit